PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT®	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80076	Hepatic function panel
82040	Assay of serum albumin
82247	Bilirubin, total
72248	Bilirubin, direct
82310	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82465	Assay of serum cholesterol
82550	Creatine kinase (CK) (CPK)

CPT®	Abbreviated Description
82565	Assay of creatine
82947	Assay of glucose, qualitative
82977	Assay of GGT
83615	Lactate (LD) (LDH) enzyme
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay pf protein
84450	Transferase (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of triglycerides
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid

Payment Calculation for Automated Tests

The automated individual and panel tests above will be paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Payment calculation is made according to the following steps:

- ≠ When a panel is performed, the CPT® codes for each test within the panel are determined.
- ≠ The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day.
- ≠ Any duplicated tests are denied.
- ≠ Then the total number of remaining unduplicated automated tests are counted. See the following table to determine the payable fee based on the total number of unduplicated automated tests performed:

Number of Tests		Fee
1	test	Lower of the single test or $10.08
2	tests	$10.08
3 -12	tests	$12.36
13 -16	tests	$16.51

Number of Tests		Fee
17 - 18	tests	$18.49
19	tests	$21.39
20	tests	$22.09
21	tests	$22.78
22 -23	tests	$23.48

Payment Calculation for Panels with Automated and Non-Automated Tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they will be priced based on:

≠ the automated multichannel test fee based on the number of tests, added to:

≠ the sum of the fee(s) for the individual non-automated test(s).

For example, panel test 80061 is comprised of two automated multichannel tests and one non-automated test. As shown below, the fee for 80061 is **$25.91.**

CPT® 80061 Component Tests	Number of Automated Tests	Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $10.08
Non-Automated: CPT® 83718		Non-Automated: $ 15.83
TOTAL FEE:		$ 25.91

Payment Calculation for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

For example, if panel codes 80050, 80076 and 80090 are performed on the same day for the same patient, the fee for the tests will be $165.75. This fee is based on the fee for the 15 unduplicated automated multichannel tests, and the sum of the fees for the six unduplicated non-automated tests.

	COMPONENT TESTS FOR CPT® CODE:				
	80050	**80076**	**80090**	**Test Count**	**Fee**
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82040* 82247* 82248 84075* 84155* 84450* 84460*	None	15 Unduplicated Automated Tests	$16.51
Non-Automated Tests	84443 85025**	None	 86644 86694 86762 86777		$ 32.40 $ 15.04 $ 25.45 $ 25.45 $ 25.45 $ 25.45
				TOTAL FEE	**$165.75**

* duplicated tests

** 80050 specifies that either 85022 or 85025 is performed; this example uses 85025

REPEAT TESTS

Additional payment will be allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters. Test(s) normally performed in a series, e.g. glucose tolerance tests, or repeat testing of abnormal results do not qualify as separate encounters. The medical necessity for repeating the test must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described above.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed for provider or practitioner, independent laboratory or outpatient hospital laboratory services as follows:

- The fee is payable only to the provider (practitioner or laboratory) who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee who is qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (e.g. gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee is not allowed when the cost of collecting the specimen(s) is minimal, such as a throat culture, Pap smear or a routine capillary puncture for clotting or bleeding time.
- No fee is payable for specimen collection performed by patients in their homes (such as stool sample collection).

Use CPT® code 36415 or HCPCS code G0001 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections are not subject to this policy and will be paid with appropriate CPT® or HCPCS codes.

No payment for travel will be made to nursing home or skilled nursing facility staff who perform the specimen collection. Travel will be paid in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider, practitioner or laboratory technician to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- the provider, practitioner or lab technician personally draws the specimen, and
- the trip is solely for the purpose of collecting the specimen. If the specimen draw is incidental to other services, no travel is payable.

Use HCPCS code P9603 to bill for actual mileage (one unit equals one mile). HCPCS code P9604 is not covered.

Payment will not be made for handling and conveyance, e.g. shipping or messenger or courier service of specimen(s) (CPT® codes 99000 and 99001). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These services are considered to be integral to the testing process and are bundled into the total fee for the testing service.

STAT LAB FEES

Usual laboratory services are covered under the Professional Services Fee Schedule. In cases where laboratory tests are appropriately performed on a STAT basis, the provider may bill local code 8949M. Payment is limited to one STAT charge per episode (not once per test). Tests ordered STAT should be limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

8949M	STAT Laboratory Fee, per episode	$11.23

The STAT charge will only be paid with the tests listed below.

CPT® Code	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay of glucose, quant
83615	Lactate (LD) (LDH) enzyme

CPT® Code	Abbreviated Description
83663	Fluoro polarize, fetal lung
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85007	Differential WBC count
85021	Automated hemogram
85022	Automated hemogram
85023	Automated hemogram
85024	Automated hemogram
85025	Automated hemogram
85027	Automated hemogram
85046	Reticucytes/hgb concentrate
85378	Fibrin degradation
85384	Fibrinogen
85595	Platelet count, automated
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

PHARMACY AND DURABLE MEDICAL EQUIPMENT PROVIDERS

PHARMACY FEE SCHEDULE

Payment for drugs and medications including all oral non-legend drugs will be based on the pricing methodology described below. Refer to Provider Bulletin 99-10 for more information on the Pharmacy Fee Schedule and WAC 296-20-01002 for definitions of Average Wholesale Price (AWP) and Base Line Price (BLP).

The department's outpatient formulary can be found in Appendix G at the end of this document.

Generic	The lesser of BaseLine Price ™ (BLP) or Average Wholesale Price (AWP) less 10% + $4.50 Professional Fee
Brand with Generic Equivalent (Substitution Allowed)	The lesser of BLP or AWP less 10% + $3.00 Professional Fee
Brand with Generic Equivalent (Dispensed as Written)	AWP less 10% + $4.50 Professional Fee
Single or multi-source brand name drugs	AWP less 10% + $4.50 Professional Fee

Compounded prescriptions will be paid at the allowed cost of the ingredients, a compounding time fee of $4.00 per 15 minutes plus the applicable professional component as indicated above.

Over-The-Counter Items

Orders for over-the-counter non-oral drugs or non-drug items must be written on standard prescription forms. These items are to be priced on a forty percent margin.

Per RCW 82.08.0281 prescription drugs and oral or topical over-the-counter medications are nontaxable.

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

Effective November 1, 1998, the department began covering Emergency Contraceptive Pills (ECPs) and associated pharmacist counseling services. These are covered only when **all** of the following conditions are met:

- a valid claim for rape in the workplace is established with the insurer,
- the ECP and/or counseling service is sought by the injured worker,
- the claim manager authorizes payment for the ECP and/or the counseling, and
- the pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication should be billed with the appropriate NDC, and the counseling service should be billed with local code 4805A. The maximum allowable amount for the counseling is listed below.

4805A	ECP counseling by a pharmacist at the time the ECP is dispensed	$33.05

INFUSION THERAPY SERVICES

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency).

Infusion therapy services (CPT® codes 90780 and 90781) and/or therapeutic, diagnostic, or vascular injections (CPT® codes 90782, 90783, 90784, 90788 and 36000-36640), are not payable to pharmacies and IV infusion companies. If nurses work for these companies providing infusion therapy services, the services must be billed with an L&I home health agency provider account number or an independent registered nurse provider account number.

Supplies used during infusion therapy, including infusion pumps, are payable only if authorized, and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Pharmacies and IV infusion companies must bill for infusion therapy supplies under their L&I provider account numbers.

Drugs used during infusion therapy, including injectable drugs, are payable only if authorized and must be billed with the NDC codes, (or UPC codes if no NDC codes are available) under an L&I pharmacy provider account number.

DURABLE MEDICAL EQUIPMENT

Pharmacies and durable medical equipment providers may bill for supplies and equipment with appropriate HCPCS and local codes (local codes for supplies are listed at the end of this section). Delivery charges, shipping and handling, tax, and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill, but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

TENS units and supplies (transcutaneous electrical nerve stimulators) are paid under special contract only. See the “Transcutaneous Electrical Nerve Stimulators (TENS) section.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

BUNDLED CODES

The concept of “bundled” codes does not apply to pharmacy and durable medical equipment providers. This is because there is no office visit or procedure associated with these provider types into which supplies can be bundled. As a result, covered HCPCS codes listed as ”bundled” in the fee schedules are payable to pharmacy and durable medical equipment providers.

HOME HEALTH SERVICES

Home health care providers, nursing homes, hospices and other residential care facilities should use the codes listed in this section to bill for services. All home health and residential care services require prior authorization. The insurer will pay only for proper and necessary care and supplies needed because of physical restrictions caused by the industrial injury or disease. The insurer will not pay for codes that are not specifically authorized.

Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

ATTENDANT SERVICES

Attendant services are proper and necessary personal care services provided to maintain the injured worker in his or her residence. All attendant services must be provided through a home health or home care agency except for continuing care from approved spouses. Spouses who provided attendant services to injured workers prior to October 1, 2001 and who meet department criteria may continue to provide attendant services.

To be covered by the department, attendant services must be requested by the attending physician and authorized by the department before care begins.

The department will determine the maximum hours of authorized attendant services based on an independent nursing assessment of the worker's care needs. Refer to WAC 296-20-303 and Provider Bulletin 01-08 for additional information.

8901H	Attendant services by department approved spouse provider (per hour)	$11.11

HOME HEALTH AND HOSPICE CARE

Approved hours will be based on health care assessments and review by the insurer. Respite care must be approved in advance. Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

The following are examples of **covered** home health care services:

- Administration of medications that can't be self-administered
- Assistance with range of motion exercises
- Bathing and personal hygiene
- Bowel and bladder care
- Changing or caring for IV's or ventilators (Only family members or licensed persons may perform these services)
- Dressing assistance
- Feeding assistance (not meal preparation)
- Mobility assistance including toileting and other transfers, walking
- Specialized skin care including caring for or changing dressings or ostomies
- Tube feeding
- Turning and positioning

The following services are considered to be “chore services” and are **not covered (except for hospice);**

- Childcare
- Errand for the injured worker
- Housecleaning
- Laundry
- Meal preparation and shopping
- Transportation
- Recreational activity
- Yard work
- Other everyday environmental needs unrelated to the medical care of the injured worker

Agency Home Health Care

8907H	Home health agency visit (RN) (per day)	$129.80
8912H	Home health agency visit (RN) each additional visit (per day)	$54.58
G0151	Services of physical therapist in home health setting, each 15 minutes (1 hour limit per day)	$32.45
G0152	Services of occupational therapist in home health setting, each 15 minutes (1 hour limit per day)	$33.62
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (1 hour limit per day)	$33.62
G0156	Services of home health aide in home health setting, each 15 minutes	$5.65
S9124	Nursing care, in the home; by licensed practical nurse, per hour	$35.89
S9126	Hospice care, in the home, per diem	BR

Nursing Evaluations

Periodic independent RN evaluation requested by the department or Self- Insurer. These services require prior authorization. Staffing evaluations required as part of the home health care plan are not payable as separate services.

8913H	Independent RN evaluation requested by the department or Self-Insurer including travel and report	$428.41

HOME INFUSION THERAPY SERVICES

Prior authorization is required for all scheduled or ongoing infusion therapy services (including supplies) provided in the home. This authorization requirement applies to all home infusion therapy regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency).

Payment for performing home infusion therapy is included with the allowed payment for home health agency nursing services. It may not be billed separately. Injections of medications also may not be billed separately.

Supplies used during home infusion therapy, including infusion pumps, are payable only if authorized, and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Bills for home infusion therapy services and supplies must be billed under the home health agency’s L&I provider account number.

Drugs used during home infusion therapy, including injectable drugs, are payable only if authorized and must be billed with the NDC codes, (or UPC codes if no NDC codes are available) under a separate L&I pharmacy provider account number.

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies provided must be medically necessary and must be prescribed by an approved provider for the direct treatment of a covered condition.

CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid. Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services.

ACQUISITION COST POLICY

Supply codes that do not have a fee listed will be paid at their acquisition cost. The acquisition cost equals the wholesale cost plus shipping and handling and sales tax. These items should be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill, but is not required.

Wholesale invoices for all supplies and material must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information

Supplies used in the course of on office visit are considered bundled and are not payable separately. Fitting fees are bundled into the office visit, or into the cost of any durable medical equipment, and are not payable separately.

Sales tax and shipping and handing charges are not separately payable, and should be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills, but is not required.

BUNDLED SERVICES AND SUPPLIES

Under the fee schedules, some services and supply items are considered "bundled" into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of a "bundled" code. Bundled codes are listed as "bundled" in the dollar value column in the Professional Services Fee schedule. Bundled services and supplies are also listed in the appendices at the end of this document.

CASTING MATERIALS

Providers should bill for casting materials with HCPCS codes Q4001 – Q4051. The department no longer accepts HCPCS codes A4580 – A4590, or local codes 2978M – 2987M. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a provider's office and used to treat a temporary obstruction. To bill for this Service, use HCPCS code G0002.

Payment for the service is not allowed when the procedure is performed on the same day as, or during the postoperative period of, a major surgical procedure that has a follow-up day period.

For catheterization to obtain specimen(s) for lab tests, see the "Pathology and Laboratory services" section.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

The department follows CMS's policy of bundling HCPCS codes A4263, A4300, A4550 and G0025 for surgical trays and supplies used in a physician's office. In 1999, CMS began a four-year process to gradually incorporate the cost of these codes into the practice expense portion (overhead) of the Relative Value Units for pertinent surgical CPT® codes. CMS completed this process in 2002. Payment for these codes is now "bundled" into the payment for the surgical procedure.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The policy for surgical dressings dispensed for home use is based on CMS's policy. If a health services provider applies surgical dressings during the course of a procedure or office or clinic visit, the cost is included in the practice expense component of the Relative Value Unit (overhead) for that provider, and no separate payment is allowed.

Primary and secondary surgical dressings dispensed by health services providers *for home use* are payable at *acquisition cost* when all of the following conditions are met:

- They are dispensed to a patient for home care of a wound, and
- They are medically necessary, and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as Telfa, adhesive strips for wound closure, petroleum gauze, etc.

Secondary Surgical Dressings

Secondary surgical dressings are material that serve a therapeutic or protective function, and that are needed to secure a primary dressing. Examples of secondary surgical dressings include items such as adhesive tape, roll gauze, binders, and disposable compression material etc. It does *not* include items such as elastic stockings, support hose, pressure garments etc. These items must be billed with the appropriate HCPCS or local codes.

In order to receive payment for dressings, providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item.

Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and will not be paid. The department or Self-Insurer may audit the use of these modifiers to ensure appropriate usage and billing.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT® code 97010) is bundled for all providers. WAC 296-20-1102 prohibits payment for heat devices for home use (this includes heating pads). These devices are either "bundled" or not covered (see appendices at the end of this document).

LOCAL CODES FOR SUPPLIES

0420A	Lumbar seat support	BR
0421A	Pressure garments	BR
0426A	Silicone elastomer/scar conformer	BR
0428A	Therapeutic exercise putty	BR
0429A	Rubber exercise tubing	BR
0430A	Anti-vibration gloves (if supplied as part of a job modification, do not bill this code, use the appropriate job modification code)	BR
0010E	Ankle weight purchase	BR
0012E	Wrist weight purchase	BR
1602L	Orthotic impression casting	BR

OTHER SERVICES

AUDIOLOGY SERVICES

A physician's prescription is required and prior authorization must be obtained from the department or Self-Insurer for all hearing related services and devices, in accordance with WAC 296-20-03001 and WAC 296-20-1101.

Hearing Aid Replacement Policy

The department will only replace hearing aids when a defective hearing aid cannot be repaired or when the department determines that an injured worker's hearing loss has worsened due to continued on-the-job exposure.

If an injured worker's hearing loss worsens and the hearing aid is no longer effective for the hearing loss, a new claim must be filed. If the new degree of hearing loss was due to continued on-the-job exposure, the claim can be accepted. If the increased loss is not due to on-the-job noise exposure the claim will be denied. The department does not pay for new hearing aids for: hearing loss resulting from noise exposure that occurs outside the workplace, non-work related diseases and conditions, or the natural aging process.

Repairs and Warranties

Hearing aid industry standards provide a minimum of a one-year warranty on most hearing aid devices, **including parts and labor.** The department or Self-Insurer will not pay for any repairs within the first twelve months.

The department will repair the hearing aid when the repair is related to normal wear or a work related incident that causes the unit to fail. The department at its sole discretion may authorize the replacement of a hearing aid in lieu of repairing the unit.

Providers must indicate in the medical or office record the length of the manufacturer's warranty and what it covers. This information must be submitted to the insurer for all hearing aid devices and hearing aid repairs provided to injured workers.

Some wholesale companies also include a replacement policy to pay for lost hearing aids. If the wholesaler/manufacturer includes loss under its warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

The department may replace the hearing aid exterior (mold) when an injured worker has ear canal changes or the mold is cracked. The department will not pay for a new set of hearing aids when only a new ear mold is needed.

Injured workers who lose or damage their hearing aids in non-work related accidents or mishaps are responsible for the expenses associated with these types of losses or damages when the manufacturer's warranty expires.

Audiology Billing Codes

All hearing aids and supplies must be billed using the following local codes. The department will only purchase the hearing aids described in these local codes. The department does not purchase 100% digital hearing aids.

5060V	6 month repair	$130.22
5061V	Repair hearing aid replate	$157.20
5062V	Repair hearing aid recase	$154.86
5063V	Repair of hearing aid remote device	$146.65
5064V	Repair of programmable hearing aid	$150.17
5065V	Hearing testing	$61.62
5066V	Body worn hearing aid	$696.52
5067V	Bone conduction hearing aid	$765.34
5068V	ITE-full shell hearing aid	$692.35
5069V	ITE-high frequency hearing aid	$769.51
5070V	In the canal & mini canal hearing aid	$942.60
5071V	ITE programmable hearing aid	$1,545.28
5072V	CIC Linear/Compression hearing aid	$1,259.58
5073V	CIC Programmable with or w/o remote	$2,154.22
5074V	BTE Linear hearing aid	$629.79
5075V	BTE Compression hearing aid	$913.41
5076V	BTE Programmable hearing aid	$1,274.18
5077V	BTE High Frequency hearing aid	$755.96
5078V	Glasses, monaural hearing aid	$777.85
5079V	Glasses, bone conduction	$1,028.10
5080V	ITE CROS hearing aid	$1,107.35
5081V	BTE CROS hearing aid	$1,332.57
5082V	Glasses, CROS hearing aid	$1,055.21
5083V	ITE BICROS hearing aid	$1,142.80
5084V	BTE BICROS hearing aid	$1,420.16
5085V	Glasses, BICROS hearing aid	$1,026.02
5086V	Hearing aid batteries, per cell	$1.04
5087V	Hearing aid cleaning kit, includes solution/brush	$10.43
5088V	Miscellaneous hearing aid supplies	BR

AFTER HOURS SERVICES

After hours services are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. The medical record must document the medical necessity and urgency of the service. *Only one of these codes will be paid per patient per day.*

These services include:

CPT®	Abbreviated Description
99050	Medical services after hrs
99052	Medical services at night
99054	Medical services, unusual hrs

INTERPRETER SERVICES

These local codes are for use by interpreters who provide language communication between injured workers and medical or vocational service providers. Refer to Provider Bulletin 99-09 for complete payment and eligibility information.

Family members, friends, medical, health care and vocational providers may provide interpretive services, but are not eligible to receive payment. Attorneys, employees of law firms, and agents of the employer of injury are not eligible to interpret or be paid for interpretive services.

When interpreter services are provided for two or more injured workers concurrently, time must be prorated among the claims. Wait time and mileage in connection with multiple claims must also be prorated. Total time billed for interpreter services and wait time for all claims must not exceed actual time spent interpreting and waiting. Total mileage billed for all claims must not exceed the total miles driven.

9980M	Interpreter services, per 15 minutes	$15.18
9981M	Wait time/form completion, per 15 minutes (maximum of 30 minutes per date of services	$15.18
9982M	Interpreter, IME no show, per 15 minutes (maximum of 30 minutes per date of service)	$15.18
9986M	Interpreter mileage, per mile	state rate
9987M	Documentation translation at insurer request only, per 15 minutes (prior authorization required for each document)	$15.18

MEDICAL TESTIMONY AND DEPOSITIONS

These local codes are for use by any provider requested by the Office of the Attorney General or the Self-Insurer to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or Self- Insurer.

Local codes 1049M, 1050M, 1053M, and 1054M are calculated on a "portal to portal" basis i.e., from the time you leave your office until you return. This does not include side trips.

The time calculation for testimony or deposition done in the provider's office or via phone is based upon the actual face-to-face time consumed for the testimony or deposition.

Code	Description	Maximum Fee
1049M	Medical testimony approved in advance by Office of the Attorney General, first hour	$384.41
1050M	Each additional 30 minutes	$128.14
1053M	Deposition approved in advance by Office of Attorney General, first hour	$320.35
1054M	Each additional 30 minutes	$107.31

NURSE CASE MANAGEMENT

All nurse case management services require prior authorization. Refer to Provider Bulletin 98-01 for a complete description of the services, provider qualifications and billing instructions.

The following local codes and fees apply to nurse case management services:

Code	Description	Maximum Fee
1220M	Phone calls per 6 minute unit	$8.38
1221M	Visits per 6 minute unit	$8.38
1222M	Case planning per 6 minute unit	$8.38
1223M	Travel/Wait per 6 minute unit	$4.12
1224M	Mileage per mile	state rate
1225M	Expenses (parking, ferry, toll fees, lodging and airfare) at cost or state per diem rate (lodging)	

Nurse case management services are capped at 50 hours of service including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases contingent upon review by the insurer.

REPORTS AND FORMS

The fees listed below include postage for sending the document to the department or Self-Insurer.

More information on some of the reports and forms listed below is provided in WAC 296-20-06101. Some department forms are available online at www.lni.wa.gov/forms. Some forms are available by completing the Medical Forms Request card included at the end of this document or online at the above web site. Special reports and forms will be sent by the department or Self-Insurer when required. All reports and forms may be requested from the Provider Hotline 1-800-848-0811.

Code	Report/Form	Maximum Fee	Special notes
CPT® 99080	Sixty Day ReportReport, Sixty day	$33.08	Sixty Day reports are required per WAC 296-20-06101 and do not need a request. Not payable for records required to support billing or for review of records included in other services. Limit of one per day.
CPT® 99080	Special Report Requested by Insurer	$33.08	**Must be requested by insurer.** Not payable for records required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit one per day.
1026M	Attending Physician Final Report (PFR)	$33.08	**Must be requested by insurer.** Payable only to attending doctor. Not paid in addition to office visit on same day. Form will be sent from insurer. Provider must retain copy of completed form. Limit of one per day.
1027M	Loss of Earning Power (LEP)	$9.31	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1037M	Physical Capacity Evaluation (PCE) or Restrictions	$21.12	**Must be requested by State Fund employer.** Payable only to attending doctor. Use for State Fund claims only. Bill to the department –see Provider Bulletin 96-10.
1039M	Time Loss Notification	$9.31	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	$25.33	Paid when initiated by the injured worker or attending doctor. Payable only to attending doctor. Limit of one per claim.
1040M	Physicians Initial Report – for Self Insured claims	$25.33	Payable only to attending doctor. Paid when initiated by the injured worker or attending doctor. Limit of one per claim.
1041M	Application to Reopen Claim	$25.33	Payable only to attending doctor. May be initiated by the injured worker or insurer. See WAC 296-20-097. Limit of one per request.
1048M	Doctors Estimate of Physical Capacities	$21.12	**Must be requested by insurer or vocational counselor**. Payable only to attending doctor. Limit of one per day.
1055M	Occupational Disease History Form	$159.57	**Must be requested by insurer.** Payable only to attending doctor. Includes review of claimant information and preparation of report on relationship of occupational history to present condition (s).
1056M	Supplemental Medical Report (SMR)	$15.65	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1057M	Opioid Progress Report Supplement	$15.65	Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See 296-20-03021 and Provider Bulletin 00-04. Limit of one per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	$33.78	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per request.
1064M	Initial report documenting need for opioid treatment	$33.08	Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and Provider Bulletin 00-04 for what to include in the report.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records when requested by the department or Self-Insurer. This fee is only payable to providers providing care or services to an injured worker. It is not payable to commercial copy centers or printers who reproduce records for providers.

Code	Description	Maximum Fee
1051M	Copies of medical records, payable to any provider when requested by the department or Self-insurer or their representative(s); not payable when required to support billing for services performed, per page. Fee includes all costs including postage.	$0.42

PROVIDER MILEAGE

Providers may bill for mileage when round trip exceeds 14 miles.

Code	Description	Maximum Fee
1046M	Mileage, per mile; allowed when round trip exceeds 14 miles	$4.23

REVIEW OF JOB OFFERS AND JOB ANALYSES

A job offer is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis.

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A job analysis is used during vocational services to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, non-work related skills, and physical limitations. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Only attending doctors will be paid for review of job descriptions or job analyses. A job description/job analysis review may be performed at the request of the State Fund employer, the insurer, a vocational rehabilitation counselor (VRC), or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (e.g. attorneys or injured workers) will not be paid. This service does not require prior authorization and is payable in addition to other services performed on the same day. Refer to the job offer guideline under WAC 296-19A guidelines (http://www.lni.wa.gov/hsa/vocational.htm.) for more information about job offers.

Code	Report/Form	Maximum Fee	Special notes
1038M	Review of Job Descriptions or Job Analysis	$33.08	Payable only to attending doctor. Must be requested by insurer, State Fund employer or vocational counselor. Limit of one per day.
1028M	Review of Job Descriptions or Job Analysis, each additional review	$16.54	Payable only to attending doctor. Must be requested by insurer, State Fund employer or vocational counselor. Limit of 5 per claimant per day. Bill to the department - see Provider Bulletin 96-10.

VEHICLE, HOME AND JOB MODIFICATIONS

Vehicle, home and job modification services require prior authorization. Refer to Provider Bulletins 96-11 for home modification information and 99-11 for job modification and pre-job accommodation information.

Code	Description	Maximum Fee
8914H	Home modification, construction and design	Maximum payable for all work is the current Washington state average annual wage
8915H	Vehicle modification	Maximum payable for all work is ½ current Washington state average wage
8916H	Home modification evaluation and consultation	BR
8917H	Home/vehicle modification mileage, lodging, airfare, car rental	State rates
8918H	Vehicle modification initial evaluation or consultation	BR
8920H	Vehicle modification follow up consultation	BR
0380R	Job modification (equipment etc.)	Maximum allowable for 0380R and 0385R combined is $5000
0385R	Pre-job accommodation (equipment etc.)	

VOCATIONAL SERVICES

Vocational Rehabilitation providers should use the codes listed in this section to bill for services. For more detailed information on billing, consult Miscellaneous Services Billing Instructions and Provider Bulletin 01-03.

All vocational rehabilitation services require prior authorization. Vocational rehabilitation services are authorized by referral type. The five referral types the department uses are: early intervention, assessment, plan development, plan implementation and forensic. Each referral is a separate authorization for services.

The department will pay interns at 85% of the VRC professional rate and forensic evaluators at 120% of the VRC professional rate. Hourly rates for professional vocational services are as follows: Vocational Rehabilitation Counselors, $75.70 per hour; Interns $64.35 per hour; and Forensic Evaluators, $91.20 per hour. Please note, however, vocational services must be billed in six-minute time increments, or ten units per hour.

Early Intervention

0800V	Early Intervention Services, VRC (per 6 minutes)	$7.57
0801V	Early Intervention Services, Intern (per 6 minutes)	$6.43

Assessment

0810V	Assessment Services, VRC (per 6 minutes)	$7.57
0811V	Assessment Services, Intern (per 6 minutes)	$6.43

Vocational Evaluation

0821V	Work Evaluation, VRC (per 6 minutes)	$7.57
0823V	Pre-Job or Modification Consultation, VRC (per 6 minutes)	$7.57
0824V	Pre-job or Job Modification Consultation, Intern (per 6 minutes)	$6.43

Plan Development

0830V	Plan Development Services, VRC (per 6 minutes)	$7.57
0831V	Plan Development Services, Intern (per 6 minutes)	$6.43

Plan Implementation

0840V	Plan Implementation Services, VRC (per 6 minutes)	$7.57
0841V	Plan Implementation Services, Intern (per 6 minutes)	$6.43

Forensic and Testimony

0881V	Forensic Services, Forensic VRC (per 6 minutes)	$9.12
0882V	Testimony on VRC's Own Work, VRC (per 6 minutes)	$7.57
0883V	Testimony on Intern's Own Work, Intern (per 6 minutes)	$6.43
0884V	AGO Witness Testimony, VRC (per 6 minutes)	$7.57

Travel, Wait Time, and Mileage

0891V	Travel/Wait Time, VRC or Forensic VRC (per 6 minutes)	$3.78
0892V	Travel/Wait Time – Intern (per 6 minutes)	$3.78
0893V	Professional Mileage, VRC (per mile)	state rate
0894V	Professional Mileage, Intern (per mile)	state rate
0895V	Air Travel, VRC, Intern, or Forensic VRC	BR

Fee Caps

Vocational services are subject to the fee caps. These caps are hard caps, with no exceptions. The following fee caps are by referral. All services provided for the referral are included in the cap.

Early Intervention Referral Cap	$1550.
Assessment Referral Cap	$2590.
Plan Development Referral Cap	$5180.
Plan Implementation Referral Cap	$4900.

The fee cap for work evaluation services applies to multiple referral types. Total payment for work evaluation services provided under all referral types will not exceed $1140. For example, if $500 of work evaluation services are paid as part of a plan development referral, only $640 is available for payment under another referral type.

Work Evaluation Services Cap	$1140.

